STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED			
		155106	B. WING		01/31/2012			
				ADDRESS, CITY, STATE, ZIP CODE	l.			
NAME OF F	PROVIDER OR SUPPLIEI	R	295 WESTFIELD RD					
RIVERW	ALK VILLAGE			ESVILLE, IN 46060				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	*	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE			
F0000								
	Teleta tata an Ca	Tu	   E0000	The Creation and submission	of			
		or Investigation of	F0000	this Plan of Correction does no				
	Complaint IN00	102531.		constitute an admission by this	s			
	Complaint INOO	102531 Substantiated.		Provider of any conclusion set				
	•			forth in the statement of deficiencies, or of any violoation	on l			
		ficiencies related to the		of regulation. This Provider	JII			
	allegation are cit	ted at F282 and F323.		respectfully requests that the				
				2567 Plan of Correction be				
	Survey dates: Ja	nuary 30 and 31, 2012		considered the letter of credib				
				allegation and requests a desl				
	Facility number: 000044			review in lieu of post survey vi	sit			
	Provider number	r: 155106		on or after 2-15-12				
	AIM number: 10	00274940						
	Survey team:							
	Michelle Hostet	er RN TC						
	Rita Mullen RN							
	Rita Widnen Riv							
	Census bed type	):						
	SNF/NF: 141							
	Total: 141							
	Census payor ty	ne·						
	Medicare: 13	P~.						
	Medicaid: 109							
	Other: 19							
	Total: 141							
	Sample: 3							
	Sample. 3							
	These deficienci	ies reflect state findings						
		nce with 410 IAC 16.2.						
	oned in accordan	110 11 10 11 10 10.2.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000044

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155106	A. BUILDING B. WING	00	COMF 01/3	E SURVEY PLETED 1/2012
RIVERW	PROVIDER OR SUPPLIEF /ALK VILLAGE	t	295 WE	ADDRESS, CITY, STATE, ZIP COI STFIELD RD SVILLE, IN 46060	JE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)  ompleted 2/4/12 by	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	Quality review of Jennie Bartelt, R	ompleted 2/4/12 by N.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UK6G11

Facility ID: 000044

If continuation sheet

Page 2 of 9

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	r í	E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		PLETED	
		155106	B. WING		01/3	1/2012	
NAME OF D	DOVIDED OD GUDDI IED		STRE	ET ADDRESS, CITY, STATE, ZIP COL	DΕ		
NAME OF P	ROVIDER OR SUPPLIER		295	WESTFIELD RD			
RIVERW	ALK VILLAGE		NOB	BLESVILLE, IN 46060			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5) COMPLETION	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	CROSS-REFERENCED TO THE APP	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
TAG			TAG	DEFICIENCY)		DATE	
F0282	•	ded or arranged by the by the by dualified persons					
SS=D		n each resident's written					
	plan of care.	reach resident 5 written					
		review and interview, the	F0282	F282 - It is the consisten	t practice	02/15/2012	
	facility failed to follow the fall care plan			of this Provider to ensure			
		at reviewed for falls in a		services provided or arra	-		
	sample of 3. [Res			provided by a qualified pe			
	Sumple of 3. [Res	naviit Dj		accordance with each residents written plan of care.I. What corrective actions will be			
	Eindings in sluds			corrective actions will be			
	Findings include	-		accomplished for those r	esidents		
	ъ	* ***		found to have been affect	ted by		
	_	on initial tour on		the alleged deficient			
		A.M., LPN #1 indicated		practice.Resident B - this			
		a high fall risk, had a		Provider was not provide resident identifier listII.			
	hi-low bed, had v	wheel chair and bed		you identify other resider			
	alarms, had a fall	l last month resulting in		having the potential to be			
	an emergency ro	om visit, and he had		by the same alleged defi-			
	brain tumors and	shunts. She also		practice and what correc			
	indicated the resi	dent had a history of		action will be taken.Resid			
		up without assistance.		need of assistance of 1 s more have the potential t			
	F. 8 8	<b></b>		affected by the same alle			
	Record review fo	or Resident B was		practice.Resident	J		
		30/12 at 10:15 A.M. The		individual needs are asse	essed at		
	_	ses included, but were		admission, change of			
	_			condition and on a quarte basis. Resident needs ar			
		gh blood pressure,		updated on resident spec			
		(stroke), seizures, and		careplans and resident	J.1.10		
	hydrocephalus.			need sheets for commun	ication to		
				staff for knowledge and o			
	-	Resident B indicated on		in providing quality care t	o each		
	10/12/11 the follo	owing interventions were		resident specific to their	oidont.		
	in place: " Prov	vide assistance for		needs.Careplans and res			
	transfers with sta	ff assistance of 2 bed		needed based on any res			
	mobility and use	of gait belt"		change. Non-compliance			
	,	<del>V</del>		facility policy and/or proc			
	Progress notes in	dicated the resident had		may result in employee			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UK6G11

Facility ID: 000044

If continuation sheet

Page 3 of 9

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155106	B. WIN			01/31/2012
),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	DOLUBER OF START				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				STFIELD RD	
	ALK VILLAGE			NOBLE	SVILLE, IN 46060	
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	re-education and/or disciplinar	5.112
	assisting resident shower room. Nu	P.M. "Nurse aide was to use the toilet in the urse aide turned to get a			action up to including terminat - which was the corrective acti taken with the identified emplo who failed to follow this Providers working system in place.III. What measures will	on pyee
		tried to transfer self from			put into place or what systema	
	w/c to toilet, and	fell on the floor. This			changes will be made to ensur	
	writer found resi	dent sitting on the floor			that the alleged deficient pract	
	next to the sink.	Resident stated, 'I tried to			does not recur?Resident chan	· .
	sit on the toilet a	nd fell.' Neuro checks			of condition are reviewed daily	•
	WNL (within no	rmal limits) can MAE			nursing management. Care plant and resident needs sheets are	
	,	ities) without difficulty.			updated based on resident	}
	`	in. Resident has an			change that may impact direct	
	• • •	left shoulder, no active			care. Nursing staff are provide	
	` ′				each shift with a current reside	
	bleeding noted. N	and family			needs sheet providing them	
	notified"				direction and required care of	
					residents.Charge nurses	
	1/7/12 at 4:45 P.I	M. This writer heard a			conducts rounds each shift to ensure resident needs sheets	aro
	crashing noise ar	nd upon investigation			used and followed by	ale
	found res (reside	nt) on floor in between			staff.Nursing staff were	
	`	ight hip on top of the			re-inserviced regarding care	
		eft side of the walker over			plans, resident needs sheets,	
		ack was lying against the			and fall prevention on 2/7/12IV	
		was lying against the			How will the corrective action	
		, , ,			monitored to ensure the allege	
	<del>-</del>	rse practitioner) was here			deficient practice will not recur what quality assurance progra	
	to assess and after	•			will be put into place?A	'''
		ROM (range of motion)			"resident care" Cqi tool will be	
	on hips determin	ed res to be ok but to			utilized daily weekly x 4 and	
	definetely (sic) n	nonitor for s/s (signs and			quarterly x 2 thereafter to mor	
	symptoms) LOC	(level of consciousness)			compliance with necessary ca	
	changes. 15 min	(minute) checks put into			and services. The governing (	
	place"				committee will review the data threshold of 90% compliance is	
	P				not met, an action plan will be	
	A CNA (Certifie	d Nurse Aide)			developed.The Director of	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UK6G11

Facility ID: 000044

If continuation sheet

Page 4 of 9

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number:  155106	A. BUILDING B. WING	COMPLETED 01/31/2012
	PROVIDER OR SUPPLIER ALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) DE COMPLETION DATE
	assignment sheet dated 1/4/12 found in the fall investigation file which was reviewed on 1/30/12 at 1:45 P.M. indicated Resident B was to be a 1 person assist.	Nursing Services is resporment for facility compliar providing necessary care a services to the residents.	nce in
	In an interview with the DoN (Director of Nursing) on 1/31/12 at 2:20 P.M., she indicated if a resident is indicated to be a two person assist, it is a given that the resident is not to be alone in bathroom and was left alone by CNA. She also indicated in training as a CNA they are told to leave a resident alone only if the resident is assessed to be able to be left alone.		
	In an interview with the Administrator on 1/31/12 at 2:25 P.M., he indicated the CNA did not follow the care plan and the facility met with CNA and disciplined her.  3.1-35(g)(2)		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UK6G11

Facility ID: 000044

If continuation sheet

Page 5 of 9

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155106	A. BUILD B. WING	DING	NSTRUCTION  00	(X3) DATE COMPL <b>01/31</b> /	ETED
	PROVIDER OR SUPPLIE	R		295 WE	ADDRESS, CITY, STATE, ZIP CODE STFIELD RD SVILLE, IN 46060		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES  NCY MUST BE PERCEDED BY FULL  R LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΈ	(X5) COMPLETION DATE
F0323 SS=D	environment rem hazards as is por receives adequate assistance device. Based on record facility failed to the restroom for 1 of 1 reside sample of 3. [Reference of the initial tour at 9:35 A.M. Durent tour, LPN #1 in high fall risk, had chair and bed almonth and was room, and that his shunts. She also a history of atternation at the sample of 1 resident's diagram of limited to, his pressure, demer seizures, and hy	was completed on 1/30/12 ruring interview on the dicated Resident B was a and a hi-low bed, had wheel arms, had a fall in the last sent to the emergency he had brain tumors and be indicated the resident had mpting to get up without  for Resident B was /30/12 at 10:15 A.M. The coses included, but were history of falls, high blood intia, CVA (stroke),	F032	3	F323 - It is the consistent prace of this Provider to to ensure the the resident environment remandas free of accident hazards as possible; and each resident recieves adequate supervision and assistance devices to prescribe accidents. I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident B the Provider was not provided with a resident identifier list. II. How will you identify other residents having the potential be affected by the same alleged deficient practice and what corrective action will be taken. Residents in need of assistance of 1 staff or more have the potential to be affected by the same alleged practice. Reside individual needs are assessed admission, change of condition and on a quarterly basis. Resident needs are updated based on resident specific careplans and resident need sheets for communication to so for knowledge and direction in providing quality care to each resident - specific to their needs. Care plans and resident needs sheets are updated daineeded based on current need of each resident and any resident needs feach resident and any resident needs resident resident and resident needs resident and resident needs resident resident needs resident needs	nat ains ains ains airs r vent r to ed ? ce nt d at n ttaff	02/21/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UK6G11

Facility ID: 000044

If continuation sheet Page 6 of 9

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIVILIDING	,	00	COMPL	ETED
		155106	A. BUILDING B. WING	J		01/31/	2012
				SEET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			STFIELD RD		
RIVERW	ALK VILLAGE				SVILLE, IN 46060		
				JULL			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAC	Ú .			DATE
		ed mobility and use of			change of condition.Non compliance with facility policy		
	gait belt"				and/or procedures may result	in	
					employee re-education and/or		
	An MDS (Minimum Data Set) assessment, dated 10/25/11, indicated				disciplinary action up to includ		
					termination - which was the		
		moderately cognitively			corrective action taken with the		
	impaired.				identified employee who failed	to	
	impanoa.				follow this Providers working system in place.III. What		
	Progress notes is	ndigated the regident had			measures will be put into place	or or	
	Progress notes indicated the resident had falls on the following dates:				what systematic changes will be		
					made to ensure that the allege		
					deficient practice does not rec	ur?	
		P.M. "Nurse aide was			Resident change of conditions	;	
	assisting residen	at to use the toilet in the			are reviewed daily by nursing		
	shower room. N	urse aide turned to get a			management. Care plans and resident needs sheets are	ı	
	walker, resident	tried to transfer self from			updated based on resident		
	w/c to toilet, and	d fell on the floor. This			change that may impact direct		
	writer found res	ident sitting on the floor			care. Nursing staff are provide		
		Resident stated, 'I tried to			each shift with a current reside	ent	
		and fell.' Neuro checks			needs sheet providing them		
		ormal limits) can MAE			direction and required care of	4	
	,	,			residents. Charge nurses cond rounds daily to ensure residen		
	· ·	nities) without difficulty.			needs sheet is used and follow		
	1	ain. Resident has an			by staff.Nursing staff were		
	` ′	left shoulder, no active			re-inserviced by the DNS		
	bleeding noted.	MD and family			regarding care plans, resident		
	notified"				needs sheets, falls and fall		
					prevention on 2/07/12.IV. How	V	
	1/7/12 at 4:45 P	.M. This writer heard a			will the corrective action be monitored to ensure the allege	-d	
	crashing noise a	nd upon investigation			deficient practice will not recur		
		ent) on floor in between			what quality assurance progra		
	,	right hip on top of the			will put into place?A "resident		
		eft side of the walker over			care" CQI tool will be utilized		
		back was lying against the			weekly x 4 and quarterly x		
					2 thereafter to monitor	r.0	
		was lying against the			compliance with necessary ca and services. The governing (		
	grab bar. NP (ni	irse practitioner) was here			and services. The governing (	JUI	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UK6G11

Facility ID: 000044

If continuation sheet

Page 7 of 9

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	ILDING	00	COMPLE	ETED		
		155106	B. WIN			01/31/2	2012		
					ADDRESS, CITY, STATE, ZIP CODE				
NAME OF F	PROVIDER OR SUPPLIE	R			STFIELD RD				
RIVERW	ALK VILLAGE				SVILLE, IN 46060				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL					ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
	to assess and af	ter doing a neuro			committee will review data - if	I			
	assessment and	ROM (range of motion)			threshold 90% compliance is r	not			
	on hips determine	ned res to be ok but to			met, an action plan will be developed.The Director of				
	definetely (sic)	monitor for s/s (signs and			Nursing Services is responsible	e to			
	symptoms) LOC (level of consciousness) changes. 15 min (minute) checks put into				monitor for facility compliance				
					providing necessary care and				
	place"	par mio			services to the residents.				
	piaco								
	A CNA (Certifi	ed Nurse Aide)							
	`	et, dated 1/4/12, was found							
		tigation file for Resident							
		eviewed on 1/30/12 at 1:45							
		nent had hand written							
		t indicated Resident B							
	_	erson assist and that							
	resident was a f	all risk.							
	In a written stat	ement by CNA#2, dated							
	1/13/12, indica	ted, "On Sat 7th around							
		esident B to the restroom,							
		oilet and gave him the call							
		m to stay there and pull							
	_	he was finished. He said							
		went to finish taking care							
	1 * *	ent when LPN #3 said							
		d crash that's when she							
		B on the floor. I was							
		esident B was not to be put							
		l left alone. I was only told							
		assist at all times.							
		been known to always pull							
		he needs help prior to this							
	incident"								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UK6G11

Facility ID: 000044

If continuation sheet Page 8 of 9

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number:  155106	(X2) MULTIPLE COI A. BUILDING B. WING	00 	COMPLETED 01/31/2012	
	PROVIDER OR SUPPLIER ALK VILLAGE	295 WE	DDRESS, CITY, STATE, ZIP CODE STFIELD RD SVILLE, IN 46060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	N
	In an interview with the DoN (Director of Nursing) on 1/31/12 at 2:20 P.M., she indicated if a resident is indicated to be a two person assist, it is a given that the resident is not to be alone in bathroom and was left alone by CNA #2. She also indicated in training as a CNA they are told to leave a resident alone only if the resident is assessed to be able to be left alone.  In an interview the DoN and Administrator further indicated on 1/31/12 at 2:50 P.M., that Resident B was cognitively intact some days and not on others. They indicated some days the resident could help when daily care was given and others was not able to. They indicated the nurse discusses this with the CNA where Resident B is at for that day and how he is doing and this is what the CNA is to follow in terms of what assistance to give.  3.1-45(a)(2)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UK6G11

Facility ID: 000044

If continuation sheet

Page 9 of 9